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## Midwifery Led Care: Antenatal Services Operational Guidelines (Mid-Ulster Locality)

### Reference Number:

NHSCT/10/341

### Target audience:

These Operational Guidelines are directed to all Midwives and Obstetric Medical staff offering Antenatal Services within Mid-Ulster Locality to pregnant women who meet the set criteria.

### Sources of advice in relation to this document:

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### NHSCT Mission Statement

To provide for all the quality of services we would expect for our families and ourselves
Midwifery Led Care: Antenatal Services

Operational Guidelines

(Mid-Ulster Locality)

September 2010
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## 1.0 Introduction

These Operational Guidelines are Directorate specific and underpin an Antenatal Services Delivery development which is designed to provide the highest quality of care whilst establishing a relationship of trust and respect with the woman. The Midwifery Led Care (MLC) Antenatal Services aim to enhance the woman’s involvement in her care and to provide flexibility and alternative accessible antenatal care options.

**Policy Statement**

The views, beliefs and values of the woman, her partner and her family in relation to her care and that of her baby should be sought and respected at all times.

Antenatal care should be readily and easily accessible to all pregnant women and should be sensitive to the needs of individual women and the local community. Women should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals (DOH, 2007). This should include where they will be seen and who will undertake their care.

The MLC Antenatal Services within the Mid-Ulster locality has been developed and implemented by the multidisciplinary Project Team in consultation with service users and expert advisers under the guidance of the Steering Group (see Table 1). This option of care is in accordance with the Maternity Services Strategy (NHSCT, 2009) in which NHSCT declare an intention to enhance patient choice.

**Target Audience**

These Operational Guidelines are directed to all Midwives and Obstetric Medical staff offering Antenatal Services within Mid-Ulster Locality to pregnant women who meet the set criteria.

### 1.1 Aims of MLC Antenatal Services Operational Guidelines

These MLC Antenatal Services Operational Guidelines will provide a clear evidenced based framework for midwives in the management and care of women who meet the set criteria and choose the MLC Antenatal Services option.

### 1.2 MLC Antenatal Services Objectives:

- Increase women’s choice of antenatal care
- Increase continuity of carer and consistency of care through a team approach.
- Increase women’s control in the decision making process.
- Increase flexibility with regards to place and times of reviews.
- Empower mothers and midwives.
- Achieve optimal outcomes in uncomplicated pregnancies
### 1.3 The Scope:

MLC Antenatal Services will be available to pregnant women who meet the following set criteria

- are assessed to be at lower risk of medical and/or obstetric complications.
- express an interest in the service
- are resident within the Mid-Ulster locality,
- are registered with a GP at a local Health Centre
- are booked with Antrim Maternity Unit

This project includes all Mid-Ulster midwives involved in providing care to lower risk women who wish to attend the MLC Antenatal Services Team. Medical advice will be available from Obstetrician colleagues and General Practitioners.

Within the context of this project it is not expected that the named midwife will provide intrapartum care unless a DOMINO or planned home birth has been arranged. The woman will attend Antrim Area Hospital, Maternity Unit for labour and birth (including DOMINO birth). Ideally, the named midwife should continue the woman's postnatal care at home, with support from the wider community midwifery team as required.

### 2.0 The Definition and Background of the Guidelines

Midwife-led and GP-led models of care may be offered to women with an uncomplicated pregnancy. Routine involvement of obstetricians in the care of women with an uncomplicated pregnancy, at scheduled times, does not appear to improve perinatal outcomes compared with involving obstetricians when complications arise (NICE, 2008).

These operational guidelines offer best practice advice based on NICE (2008) guidance for the ‘Antenatal Care: Routine Care for the Healthy Pregnant Woman’. The MLC Antenatal Services Team will offer care for women whose pregnancy is perceived to be at lower risk of complication and who choose this service.

### 2.1 Legislative Compliance

The provision of MLC Antenatal Services is in accordance with local, regional and national guidelines which state that women and their families must have access to greater choice, control and continuity within the maternity services.

The Operational Guidelines should be read in conjunction with the following documents – ‘Midwives Rules and Standards’ (NMC, 2004), ‘Maternity Matters’ (DOH, 2007), ‘Antenatal Care’ (NICE, 2008), ‘A Strategy for the Maternity Service 2009-2014’ (NHSCT, 2009), ‘The Role of GPs in Maternity Care’ (Smith, 2010).
3.0 **Roles and Responsibilities**

3.1 **Lead Health Care Professional**

All women will be ‘Booked’ and have a risk assessment by a midwife preferably by 10+6 weeks (NICE, 2008). All women will be offered a Consultant Obstetrician clinic appointment by 13+6 weeks (CEMACH, 2007). The ‘Lead’ healthcare professional will be agreed and documented on the Maternity Hand Held Record (MHHR) as ‘MLC’ (Midwifery Led Care) Team or the name of the Consultant Obstetrician.

The MLC midwives will have full referral rights when liaising with colleagues e.g. GPs, consultant obstetricians, ultrasonographers, social worker etc.

3.2 **Midwifery Led Care Team**

The Midwifery Led Care Team will comprise of named midwives from the Mid-Ulster Community Midwifery Team who will attend women at the two ‘booking’ clinics and the Antrim Area Hospital satellite review clinic located at the Mid-Ulster Hospital, Magherafelt.

At the ‘Booking’ clinic the MLC midwives will

- initiate the Maternity Hand Held Record (MHHR)
- review the GP Referral Letter (*see appendix 1*)
- complete the NIMATs booking and insert print-out in MHHR
- identify lower/higher risk women using the Risk Assessment Tool (*see appendix 2*)
- obtain A/N blood samples with informed consent
- perform the dating USS (phased approach)
- record observations and initiate the fetal growth chart
- give and discuss health promotion information
- discuss ‘Place of Birth’ options with ‘Lower Risk’ women
- discuss Midwife Led Care A/N Appointments Schedule (*see appendix 3*)
- offer and arrange Consultant appointment by 13+6 weeks and at 40 weeks
- arrange next appointment for MLC review clinic at 16-18 weeks
- refer to specialist services if appropriate
- record preference and ‘Lead’ professional in MHHR

MLC Review Clinics will be

- held at the Mid-Ulster hospital, at 16-18 weeks to review and file blood reports, review USS reports and record observations.
- all other review appointments will be offered at GP health centres

Prior to commencing the MLC Antenatal Services planning phase the Pre-MLC Antenatal clinic activity was evaluated. Table 3 demonstrates that primiparous women attended on average 13 routine appointments and parous women attended on average 11 routine appointments. This should be compared with the proposed
Midwifery Led Care- Antenatal Appointments Schedule which has been adapted from the ‘Antenatal Care: Routine Care for the Healthy Pregnant Woman’ (NICE, 2008). Normal healthy antenatal women will be offered on average 10 appointments (primagravidas) and 9 appointments (parous) and a USS appointment at 18+6-20+6 weeks (see appendix 3). Additional appointments may be arranged at the request of the woman and at the discretion of the midwife.

3.3

**Named Community Midwife**

Continuity of carer and care has been a key policy principle since the early 1990s. Outcomes of randomised control trials highlight that women value continuity of carer in the antenatal and postnatal periods (NHS QIS, 2009). It is, therefore, recommended that a named community midwife is allocated for each woman's antenatal and postnatal care. Where possible, this midwife should be the first point of contact for the pregnant woman who can self refer or referrals can be made by the GP or Obstetrician.

Named community midwives within NHSCT are geographically based and are usually GP attached. The ‘named’ midwife’s name should be recorded on the MHHR and she/he should plan and provide the majority of the woman's antenatal care, with support from the MLC Antenatal team, GP or Obstetrician as required.

3.4

**The Obstetrician**

All women will be offered a consultation with an Obstetrician by 13+6 weeks (CEMACH, 2007). All women will attend a Midwifery ‘Booking’ clinic, which runs in parallel with an Obstetrician Led clinic therefore a consultation can be facilitated at this time. Lower risk women will be offered another Consultant Obstetrician clinic appointment at 40 weeks.

Should complications arise during the pregnancy for lower risk women under MLC, a medical opinion will be sought, and if appropriate the care will be transferred to the consultant and his/her team (see appendix 4). Lower risk women may be transferred back to the MLC antenatal team at the Obstetrician’s discretion.

Women with more complex needs would normally have Obstetric Led care with the Consultant's name recorded as ‘lead’ professional on the MHHR. The named midwife will continue to provide community based care in conjunction with the Obstetrician who has professional accountability for the case.

3.5

**The Ultrasonographer**

The USS clinics will operate on the same day/time as a Consultant Obstetric or Gynaecology clinics. The ultrasonographer will take direct referrals from the MLC team midwife for the anomaly ultrasonic scan (USS) between 18+6 -20+6 weeks. The ultrasonographer will review the NIMATs Booking printout in the MHHR and take a full history from the woman. Consent will be recorded in the MHHR. The USS Report will be filed in the brown envelope at the back of the MHHR. The EDD will be confirmed. If there is a discrepancy of more than 10 days the woman will be referred to the named
Consultant Obstetrician for adjustment of dates.

Should complications arise for a lower risk woman, the ultrasonographer will refer the woman directly to the Consultant Obstetrician and will inform the MLC Team at the earliest opportunity. Should problems arise during the pregnancy the MLC midwife will refer the woman to the Consultant Obstetrician's clinic or Fetal Maternal Assessment Unit if considered urgent.

If the woman fails to attend for her USS appointment the ultrasonographer will inform the OPD clinic desk receptionist who will inform the MLC midwife (as before). The midwife will check that the pregnancy is ongoing and will contact the woman to arrange the next USS appointment with the OPD administration staff.

3.6 The General Practitioner

The General Practitioners (GP) will refer the woman to the Antenatal Clinics at the Mid-Ulster Hospital, Magherafelt as before. The GP’s knowledge of the woman’s medical history is crucial and this information needs to be communicated effectively if the woman’s level of risk is to be assessed accurately.

GPs will be urged to provide comprehensive information about the woman’s significant obstetric and medical history to midwives who will be performing risk assessment at the Mid-Ulster Antenatal clinics. The current format for providing information is the GP Referral letter. However, the content and depth of information in GP referral letters may vary widely.

A template Antenatal Referral Letter has been developed which can be adapted to suit the different computer systems used by local GPs (see appendix 1). This template Antenatal Referral Letter will be replaced by the Regional Antenatal Referral Letter when it becomes available.

The type of information that it is important for the Maternity Services to know about includes

- GP name and HC contact details
- Woman’s name, demographic details, previous name
- Health and Care Number, DOB, telephone and mobile number
- If an Interpreter is required and if so identify the first language
- Past and current obstetric history, LMP, EDD, gestation
- Significant past and current medical history, BMI, B/P, mental health issues
- Past and current social risks, drugs/alcohol misuse, smoking status
- Current medication, folic acid, known allergies
- Type of antenatal care requested

The MLC Team will inform the GP in writing when a woman opts for MLC Antenatal services (see appendix 5).

The GP will have ongoing responsibility for the woman’s medical care throughout pregnancy and postnatal period, including responsibility for the baby’s ongoing
medical care as required.

The woman may consult her GP at any time during the pregnancy, as he/she plays an important role in continuing to provide her with general medical care (Smith et al, 2010)

3.7

**The Health Visitor**

Care of healthy mothers and babies is normally transferred to the health visitor anytime from day 10 postnatal and she/he has responsibility for the ongoing care of healthy children until school age.

4.0

**Process for Recruiting Women to Midwifery-Led Care**

Women can book directly, ask the GP to refer them to the MLC Team or opt for MLC Antenatal Services at her first hospital ‘Booking’ appointment.

When a woman consults her GP or is booking at the Mid-Ulster antenatal clinic she should be informed her of all the options of care so she can make an informed decision regarding her choices.

MLC Antenatal Services will be available to pregnant women who

- are assessed to be at lower risk of medical and/or obstetric complications.
- express an interest in the service
- are resident within the Mid-Ulster locality,
- are registered with a GP at a local Health Centre
- are booked with Antrim Maternity Unit

4.1

**Antenatal Schedule**

The antenatal schedule for the lower risk woman has been developed from NICE guidelines (NICE, 2008) and agreed with the multidisciplinary team as outlined in Appendix 3.

- Currently 2 ‘Booking’ clinics for MLC
  - Monday pm
  - Thursday pm
- Review Clinic - Friday 1.30 pm for women between 16-18 week gestation
- Flexible reviews - at hospital, health centres or at home
- Consultant Obstetrician referral if clinically indicated or woman requests
- USS (with the woman’s consent)
  - viability and dating scan by 13+6 weeks
  - structural scan @ 18+6-20+6 weeks

4.2

**Risk Assessment**

It is the midwife’s duty to identify the perceived benefits and possible risks associated with different options for antenatal care within the context of the woman’s individual circumstances. A woman who meets the set criteria outlined in section 1.3 can make the choice to opt for MLC Antenatal Services at booking or at any stage of pregnancy.

The booking history should include a review of the GP’s Antenatal Referral letter and
utilization of local computerized antenatal screening tools. For example, NIMATs is the ‘booking’ system currently used within the Northern Heath and Social Care Trust (NHSCT). The NIMATs booking report should be agreed with the woman and a printed copy inserted in the MHHR. Taking a sound history will generate discussion about identified risks and how they can be managed. Women under the care of the MLC Antenatal Services will be offered a range of antenatal screening services which will also help to identify risks (see appendix 3).

The presence or absence of risk may change during pregnancy and the midwife should remain alert to risk factors and signs or symptoms of conditions that may affect the health of the mother and baby (see appendix 2). The woman should be encouraged to report any concerns to her midwife or GP. The midwife must take care to pre plan to mitigate identified risks by referring or transferring care to the obstetrician as these women may require additional obstetric care. Following assessment women may return to MLC at the discretion of the Obstetrician. The criteria outlined in Appendix 2 is not intended to be exhaustive. Risk assessment should be ongoing for any woman presenting with any other condition that the midwife, GP or Obstetrician deems to require consultant led care.

<table>
<thead>
<tr>
<th>4.3 Transfer</th>
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<tbody>
<tr>
<td>A clear transfer pathway is essential so that pregnant women who require additional care are managed and treated by the appropriate specialist teams when problems are identified. It is expected that women will transfer between midwife led and obstetric led care as risks alter (see appendix 4). However, it is anticipated that women will continue to have choice in relation to the lead professional for their care.</td>
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<tr>
<th>5.0 Fetal Maternal Assessment Units (FMAU)</th>
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<tbody>
<tr>
<td>If a woman who is booked with the MLC Antenatal Team attends the FMAU, the midwife and/or Doctor On-Call should assess her as usual and inform the MLC Antenatal Team of the outcome of the assessment.</td>
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<tr>
<th>5.2 MLC women admitted to Antenatal or Gynaecological ward</th>
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<tbody>
<tr>
<td>When a woman who is booked with the MLC Antenatal Team, is admitted to the antenatal or gynaecological ward with any complication during the pregnancy, the responsibility for care is shared with the Consultant On-Call for that day. It is the ward midwife/nurse’s responsibility to ensure that the woman is reviewed daily by the medical team and that she is not treated differently to other antenatal inpatients. The admissions midwife/nurse should inform the MLC Antenatal team of the admission. If the complication is minor, once resolved, the MLC Antenatal team will resume the role of lead professional for the woman's maternity care. However, if deemed appropriate a woman who experiences a complicated pregnancy will be transferred to Consultant-led care.</td>
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</table>
5.3 **Intranatal**
Within the context of this project it is not expected that the named midwife will provide intrapartum care. Unless the woman has planned to have a home birth, she will attend Antrim Area Maternity Unit for labour and birth.

5.3 **Postnatal:**
If the mother or baby needs to be assessed by a doctor, the ward midwifery staff will request this and will advise the ward sister or midwife-in-charge of her decision. All babies will be examined following routine neonatal care procedures. The discharge referral will be made to the Mid-Ulster community midwifery team who will co-ordinate visits for those mothers who reside within the Mid-Ulster locality.

The standard hospital discharge letters CHS3a &b will continue to inform the community midwife, GP and HV of the birth of the baby. Liaison with the Health Visitor will follow normal procedure.

6.0 **Documentation**
Good communication between healthcare professionals and women is essential.

6.1 **Regional MHHR**
The regional Maternity Hand Held Records (MHHR) will be carried by the woman throughout her care and the relevant records will be completed and filed appropriately by the multidisciplinary team. All health care professionals will record any identified risks, the plan of care, observations, treatment, evaluation of care given, referrals and transfers.

**MLC, the Consultant’s name and the ‘named’ midwife’s name should be recorded on the inside front page of the MHHR.** The named midwife’s office contact number will be recorded on the MHHR for non-urgent antenatal queries and advice.

The NHSCT PAS Questionnaire will be filed in the MHHR.

6.2 **MLC A/N Care Appointments Schedule**
The MLC A/N Care Appointments Schedule has been developed from NICE guidance (NICE, 2008) (see appendix 3). The Schedule will be printed on green paper and inserted in the front of the MHHR at the first appointment as a guide for focused activities and will be used as an appointments diary.

6.3 **General Practitioner Referral Letters**
The information provided by the GPs in the Referral Letter is regarded as the start of the Risk Assessment process. Incomplete medical information may mean that the woman is assessed as lower risk when in fact she may have complications warranting Consultant Care. The Antenatal Referral Letter Template outlines the baseline information required (see appendix 1). Additional information can be recorded in the
free text section. The GP Antenatal Referral Letter should be filed in the MHHR.

### 6.4 Letter to GP

When a woman opts for the MLC Antenatal service, the team will write to the GP to inform her/him of the woman’s choice of care (*see appendix 5*).

The named midwife or representative will attend the health centre based antenatal review clinics and record observations on the GP’s information system and in the MHHR.

The standard hospital discharge letters CHS3a &b will continue to inform the GP of the birth of the baby.

### 6.5 Antenatal Referral and Transfer of Care:

If referral or transfer to the Consultant Obstetrician is required during the antenatal period the MLC midwife will discuss the issues with a senior obstetrician and the woman. The Referral/Transfer form will be completed by the MLC midwife and sent to the Consultant Obstetrician (*see appendix 4*). A copy will be retained in the MHHR and a copy forwarded to the GP for future reference. In addition a copy should be forwarded to the MLC office for monitoring purposes.

When referral or transfer of care is necessary, the following information will be recorded in the appropriate antenatal section of the mothers MHHR.

**Documentation should be concise and include:**

- The date and time of referral or transfer of care
- The named ‘booking’ Consultant Obstetrician to whom the woman is being referred i.e. for an antenatal clinic appointment or fully transferred
- The name of the obstetrician in charge of the antenatal ward, gynaecological ward or FMAU to whom the referral has been made.
- Review of all elements of the case
- Reason for referral and actions taken

If the problem is resolved the MLC Team will resume care for this woman. There should be a review of the case and a written plan of care as agreed with the obstetric team.

If the problem or complication persists then complete transfer of care is made to the relevant ‘booking’ Consultant Obstetrician after discussion with a senior obstetrician and the woman. Following transfer, the Consultant Obstetrician’s name will be documented on the front of the mother’s MHHR and the clerical staff will change her ‘care’ and ‘lead professional’ on the PAS system.

### 7.0 PAS

All women referred to Mid Ulster antenatal clinics will be booked initially for a Consultant Led Service (there will be no direct booking to MUH MLC for 1st appointments). The Referral is registered on PAS to either Dr Stewart or Dr El
Tuhamy’s Obstetric ‘Booking’ clinic (see appendix 7).

**MLC OAN - MLC Antenatal Clinic**
**FS OAN - Dr Stewart Antenatal Clinic**
**SET OAN - Dr Tuhamy Antenatal Clinic**

### 7.1 Clinic Codes
At the first appointment the midwife will conduct a Risk Assessment in consultation with the woman and the Consultant Obstetrician or deputy. If the woman is considered suitable, she may choose the MLC option for future antenatal care. The OPD clerk will be informed by the midwife via the ‘Obstetric/MLC Booking Appointment Note’ that the woman has been accepted for MLC care (see appendix 6a). The OPD Clerk will return these notes to the MLC midwife at the end of the clinic for monitoring purposes.

When making the appointment for the next hospital visit (16-18 weeks) the OPD clerk will open a ‘new registration’ on PAS for the “MLC” Clinic template. This will be the first attendance at a MLC clinic so it will be booked on PAS as a “NEW” appointment slot.

The majority of the review clinics will be at the woman’s GP Health Centre but subsequent attendances at the MLC hospital clinic should be booked on PAS as MLC “Follow Up” attendances.

OAN registration for the Consultant Service should remain OPEN so that woman can be booked in as a REVIEW patient if she needs to be seen at Consultant clinic again during pregnancy (referral back for consultation/opinion). The same Consultant code will be used when a MLC woman is seen at the Fetal Maternal Assessment Unit or admitted to hospital as an antenatal patient.

**Closing the MLC OAN Episode**
When an antenatal woman’s care has been transferred to an Obstetrician the MLC midwife will inform the OPD clerk who will close the MLC code and keep open the Consultant code.

When the woman is admitted to Antrim Area Hospital for Intrapartum Care both the MLC OAN Registration and the original Consultant Led OAN Clinic registrations should be closed on PAS

### 7.2 Lab Codes
The midwife will record ‘MLC’ in place of ‘Doctor’s’ name in the appropriate box on the Laboratory form. The Lab reports will be returned to the Community Midwifery Office at the Mid-Ulster Hospital. The midwives will take responsibility for checking and filing the reports in the woman’s MHHR at the 16-18 week appointment. Any abnormal results will be reported to the GP or Consultant as appropriate.

### 8.0 Team organisation:
The MLC Antenatal Team roster their own off-duty to meet the needs of the service.
Flexibility is vital to the success of the team. Holiday and/or study leave must be agreed by the Team Leader to ensure full cover is provided at all times.

Staff development and performance is mandatory within the NHSCT and each team midwife must take responsibility for ensuring that the annual appraisal process is completed and that her training and development needs are met. Compulsory study attendance must be incorporated into rotas. Attendance at mandatory Trust training will include fire lectures, manual handling, PROMPT (includes emergency drills, CPR for adults and neonates), K2/CTG updates. The midwives will inform the Team Leader of all training attended and records must be available for inspection.

### Monitoring

**Target:** This project aims to recruit 30% of the total women booking for the Mid-Ulster Antenatal Clinics in the first year. This target will be reviewed after 12 months.

**Monitoring:** Minutes of MLC team meetings will be submitted to the Team Leader to so that all staff are aware of activity. Recommendations for change or issues to be resolved will be presented to the Team Leader.

The MLC team will produce, analyse and submit monthly statistics to the Team Leader by the third day of each month for monitoring purposes.

Midwives will monitor clinical outcomes using:

- The ‘Obstetric/MLC Booking Appointments Slip’ will inform the OPD clerk that the woman has been accepted for MLC care and this will be recorded on PAS (*see appendix 6a*). The OPD Clerk will collect these Slips and return them to the MLC midwife at the end of the clinic as they will be required for monitoring purposes.

  The ‘Booking’ Slips will provide data on the total number of women who
  - attended the ‘Booking’ Clinic
  - met the set criteria and chose MLC Antenatal Services option
  - were seen by the MLC midwife, Consultant Obstetrician, Staff Grade, or SHO
  - met the set criteria and did not choose MLC Antenatal Services
  - reasons for not choosing MLC A/N services
  - were not suitable for MLC Antenatal Services
  - reasons why not suitable for MLC A/N services

- The ‘Obstetric/MLC 40 Weeks Appointments Slip’ will provide information for the MLC midwives (*see appendix 6b*). The OPD Clerk will collect these Slips and return them to the MLC midwife at the end of the clinic as they will be required for monitoring purposes.

  The ‘40 Weeks’ Slips will provide data on the total number of women who
  - initially chose the MLC Antenatal Services option
  - remained under MLC throughout A/N period
  - were seen by MLC Midwife, Consultant Obstetrician, Staff Grade or
SHO
- had not chosen MLC Antenatal Services option
- were not suitable for MLC A/N Services option

Outcomes Evaluation: for MLC A/N women only will provide information on the number of women who were
- referred (at any stage) to Consultant Obstetrician Led A/N Care
- referred by the MLC midwife or GP; gestation and reason
- how many returned to MLC A/N Care and gestation
- remained under Consultant Care
- fully transferred to Consultant Obstetrician Led A/N Care; gestation and reason

- A copy of the Referral/Transfer letter will be forwarded to the MLC office for monitoring purposes (see appendix 4).
  This should provide data on the number of referrals and transfers to an Obstetrician and the reasons why.
- When an antenatal woman’s care has been fully transferred to an Obstetrician the MLC midwife will inform the OPD clerk who will close the MLC code and keep open the Consultant code.
  A monthly PAS report will be generated – this should provide further data for cross referencing the number of new MLC cases opened and the number closed each month.

Regular review of the service will be carried out by the Team Leader on an ongoing basis and quarterly and annual reports will be forwarded to the Lead Midwife and Head of Midwifery.

Dependent on the availability of resources, research comparing the efficacy of the clinical outcomes of MLC Antenatal services with those of conventional care may be undertaken.

**Implementation / Resource requirements:**

**Training**
For this project to be successful a large cohort of midwives who have completed a recognised USS education course and gained the necessary experience will be required.
Note: 14 midwives in total. At the outset 4 can USS independently. 10 require training.
It will take approximately 5 years for 10 midwives to undertake an appropriate USS module e.g. QUB, double module, over 1 academic year.
Resources will include backfilling hours to release midwives, application fees, travel expenses, time etc.

**Equipment**
USS machine: to help avoid delays it has been identified that one additional USS machine is required.

Photocopier: to facilitate photocopying of relevant information for MLC clinics
11.0 References


Bibliography


12.0 Consultation Process
See Table 2
| 12.1 | **Versions V1.0 and V1.2**  
Versions 1.0 – V 1.2 of the Mid-Ulster ‘Midwifery-Led Care Antenatal Services Operational Guidance’ and appendices were forwarded by email to the Steering Group and Project Team for comment and amended where necessary. |
| --- | --- |
| 12.2 | **Version 1.3**  
Version 1.3 was circulated to the following for information and onwards circulation to all relevant staff groups for comment and further amendments where necessary.  
1. Clinical Director of Acute Services – Dr McMillen  
2. Assistant Director of Acute Services – Margaret Gordon  
3. Head of Midwifery – Mary Maxwell  
4. Project Team – Dr Tuhamy, Dr Stewart, Marie Kyne, Paula Mulholland, Susan Murphy, Marie Kyne, Gillian Morrow, Maggie Walls, Lynn McImoyle, Katy Fulton  
5. Corporate Communications – Margaret Mulholland, Michelle McNaughton and Don Heaney  
6. Consultant Obstetricians, Causeway – Dr Obyrcki, Dr Nawaz, Dr Johnston, Dr Marshall  
7. Consultant Obstetricians, Antrim – Dr Ritchie, Dr Ashe, Dr Dorman, Dr Johnston  
8. Service Users – see Table 1  
9. Practice Development Midwife – Gillian Morrow  
10. Lead Ultrasonographer - Heather Beattie  
11. Ultrasonographer - Lizzie Lennox, Mid-Ulster Hospital  
12. Family Practitioner Unit and local GPs via Intranet Website address: [http://gpfpu.hpssweb.n-i.nhs.uk/index.asp](http://gpfpu.hpssweb.n-i.nhs.uk/index.asp)  
13. Antenatal Clinic Managers – Agnes Flood, Antrim and Barbara Strawbridge, Causeway  
15. Lead Midwife for Inpatients Services – Sinead O’Kane  
16. Ward Manager- Irene McKay, Antrim  
17. Lead Midwife for Delivery Suite and Governance – Caroline Keown  
18. Clinical Governance and Risk Management Midwife – Gwyneth Peden  
19. Community Midwifery Team Leaders – Jacqueline Robinson, Causeway and Mid-Ulster and Martina Doolan, United  
20. All NHSCT Community Midwives  
21. Antenatal Screening Co-ordinators – Nora McClanaghan, Antrim and Mid-Ulster and Lorna Hawe, Causeway  
22. Parentcraft and Breastfeeding Co-ordinator – Rosemary Kerr  
23. Breastfeeding Co-ordinator – Gillian Anderson  
24. LSAMO - Verena Wallace  
25. Contact Supervisors of Midwives: Karen Graham, Causeway and Geraldine Burton, AAH  
26. Head of Public Health Nurses – Susan Gault  
27. Lead Nurses for Public Health (Health Visitors) – Sheila McElwee and Maeve McGuigan  
28. Lead Nurse for Child Protection – Amber McCloughlin  
29. NHSCT Laboratory General Manager - Pathology – Geoff Kennedy,  
30. NHSCT Laboratory General Administrative Assistant.- Mary Dempsey  
31. Patient Administration Officers - Heather Simpson and Mary McWilliams |
| 12.3 Policy Screening  
**Equality, Human Rights and DDA**  
These Guidelines have been drawn up and reviewed in the light of Section 75 of the Northern Ireland Act (1998) which requires the Trust to have due regard to the need to promote equality of opportunity. It has been screened to identify any adverse impact on the 9 equality categories and no significant differential impacts were identified, therefore, an Equality Impact Assessment is not required.  
  
**Alternative formats**  
This document can be made available on request on disc, larger font, Braille, audio-cassette and in other minority languages to meet the needs of those who are not fluent in English.  
  
**Sources of Advice in relation to this document**  
The Guidelines Author, responsible Assistant Director or Director as detailed on the policy title page should be contacted with regard to any queries on the content of this policy.  

| 13.0 Communication Plan  
The Communication Plan has been developed in conjunction with the Corporate Communications team.  
See appendix 8 – Letter of Information  
See Appendix 9 – Patient Information Leaflet |
Table 1: Mid-Ulster MLC Antenatal Services Steering Group and Project Team

<table>
<thead>
<tr>
<th>Steering Group</th>
<th>Project Team</th>
</tr>
</thead>
</table>
| **Dr McMillen,** Clinical Director **Margaret Gordon,** AD | **Dr Frances Stewart,** Consultant Obstetrician  
**Dr Tuhamy,** Consultant Obstetrician  
**Brigid McKeown** – Lead Midwife for Community Midwifery Services and Public Health  
**Paula Mulholland,** Lead MW A/N Clinics & Gynae  
**Susan Murphy,** Business Planning Manager  
**Marie Kyne,** Midwife and SOM  
**Gillian Morrow,** Practice Development MW  
**Maggie Walls,** Service user  
**Lynn McImoyle,** Service user  
**Katy Fulton,** Service user  
**Family Practitioner Unit:** GP representatives |
| **Mary Maxwell,** HOM | **—** |
| **Quality Assurance**  
Causeway Consultant Obstetrician | **—** |

Table 2: Guidelines Development and Consultation

<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Author</th>
<th>Comments</th>
</tr>
</thead>
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<tr>
<td>27th July 2010</td>
<td>V. 1.0</td>
<td>Brigid McKeown</td>
<td>Circulated to Steering Group, Project Team and Corporate Communications</td>
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<tr>
<td>02nd August 2010</td>
<td>V. 1.1</td>
<td>Brigid McKeown</td>
<td>Circulated to Steering Group, Project Team and Corporate Communications</td>
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<tr>
<td>16th August 2010</td>
<td>V. 1.3</td>
<td>Brigid McKeown</td>
<td>Circulated to Steering Group, Project Team and Corporate Communications. MLC team, Midwifery and Obstetric colleagues, SOMs Governance Midwife and expert advisers – see section 12.2</td>
</tr>
<tr>
<td>02nd September 2010</td>
<td>V. 2.0</td>
<td>Mrs Margaret Gordon, AD</td>
<td>Submitted to NHSCT Policy Standards and Guidelines Committee and Policy Committee</td>
</tr>
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<td></td>
<td>V 2.0</td>
<td>Policy Committee</td>
<td>Trust Intranet</td>
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**Table 3: Pre-MLC Activity (August 2009)**

<table>
<thead>
<tr>
<th>Routine Appointment</th>
<th>Pre-MLC Activity (August 2009)</th>
<th>Additional new activities introduced by MLC</th>
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<tbody>
<tr>
<td></td>
<td>Prims – 13 routine appointments</td>
<td>Prims – 10 routine appointments</td>
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<td></td>
<td>Parous- 11 routine appointments</td>
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</tr>
<tr>
<td></td>
<td>not inc USS at 20 wks</td>
<td>not inc USS at 20 wks</td>
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<td>Booking</td>
<td></td>
<td>Mon and Thur Joint clinics</td>
</tr>
<tr>
<td>Prims and Parous</td>
<td></td>
<td>&lt; 10+6 weeks</td>
</tr>
<tr>
<td>Community midwife</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Friday Midwife only clinic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&lt; 12+6 weeks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prims and Parous</td>
<td></td>
</tr>
<tr>
<td>Obstetrician 1st</td>
<td></td>
<td></td>
</tr>
<tr>
<td>appointment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thursday Joint clinics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&lt; 10+6 weeks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prims and Parous</td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Friday Midwife only clinic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&lt;12+6 weeks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prims and Parous</td>
<td></td>
</tr>
<tr>
<td>Reactive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
<td>Daily</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Women collected MHHR with Blood results filed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Routine A/N observations</td>
<td>Friday Midwife only clinic As Before</td>
</tr>
<tr>
<td>10 - 13+6 wks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prims and Parous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant</td>
<td></td>
<td></td>
</tr>
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<td>1st appointment</td>
<td>Routine A/N observations</td>
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<td>16 - 18 wks</td>
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<td></td>
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<tr>
<td>Prims and Parous</td>
<td>Women collected MHHR</td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
<td>Blood results filed</td>
<td>Friday Midwife only clinic As Before</td>
</tr>
<tr>
<td></td>
<td>Routine A/N observations</td>
<td></td>
</tr>
<tr>
<td>18 - 20+6 wks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prims and Parous</td>
<td>Ultrasound screening for structural anomalies</td>
<td>As before</td>
</tr>
<tr>
<td>Ultrasoundographer</td>
<td>Confirm gestational age</td>
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</tr>
<tr>
<td>21 wks</td>
<td>Routine A/N observations</td>
<td></td>
</tr>
<tr>
<td>Prims and Parous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
<td>Routine A/N observations</td>
<td></td>
</tr>
<tr>
<td>25 wks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prims and Parous</td>
<td>Review USS report</td>
<td>As before</td>
</tr>
<tr>
<td>Midwife</td>
<td>Routine A/N observations</td>
<td></td>
</tr>
<tr>
<td>28 wks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prims and Parous</td>
<td>Obtain bloods</td>
<td>No routine appointment</td>
</tr>
<tr>
<td>Midwife</td>
<td>Review, discuss and record 28 wks blood</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td>30 wks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prims</td>
<td>Routine A/N observations</td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
<td>Review, discuss and record 28 wks blood</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32 wks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prims and Parous</td>
<td>Routine A/N observations</td>
<td>Primigravidas only</td>
</tr>
<tr>
<td>Midwife</td>
<td></td>
<td>No routine appointment for Parous women</td>
</tr>
<tr>
<td>34 wks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prims and Parous</td>
<td>Routine A/N observations</td>
<td>Midwife only clinic</td>
</tr>
<tr>
<td>Consultant</td>
<td>Review, discuss and record 30 wks blood results</td>
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</tr>
<tr>
<td>36 wks</td>
<td>Routine A/N observations</td>
<td>Prims and Parous</td>
</tr>
<tr>
<td>Prims</td>
<td>Breastfeeding technique and management</td>
<td>As before</td>
</tr>
<tr>
<td>Midwife</td>
<td></td>
<td></td>
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<tr>
<td>38 wks</td>
<td>Routine A/N observations</td>
<td>As before</td>
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<tr>
<td>Prims and Parous</td>
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<td></td>
</tr>
<tr>
<td>Midwife</td>
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</tr>
<tr>
<td>40 wks</td>
<td>Routine A/N observations</td>
<td>As before except membrane sweep</td>
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<tr>
<td>Prims and Parous</td>
<td>Arrange IOL date (T+10 - T+14) give IOL pack</td>
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<tr>
<td>Consultant</td>
<td>Offer membrane sweep</td>
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</tr>
<tr>
<td>41 wks</td>
<td>Routine A/N observations</td>
<td>As before and offer membrane sweep</td>
</tr>
<tr>
<td>Prims and Parous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
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</table>
Appendix 1: ANTENATAL REFERRAL LETTER

<table>
<thead>
<tr>
<th>Referred to: Hospital</th>
<th>GP:</th>
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</thead>
<tbody>
<tr>
<td>Consultant:</td>
<td>GP Code:</td>
</tr>
<tr>
<td>Name: (M/S/Sep/W)</td>
<td>Health/Medical Centre:</td>
</tr>
<tr>
<td>Address:</td>
<td>Practice Code:</td>
</tr>
<tr>
<td></td>
<td>Contact No:</td>
</tr>
<tr>
<td></td>
<td>GP Cyper Code:</td>
</tr>
<tr>
<td></td>
<td>Health and Care No:</td>
</tr>
<tr>
<td>Post Code:</td>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Previous Name:</td>
<td>Home Tel. No:</td>
</tr>
<tr>
<td>Name:</td>
<td>Mobile No:</td>
</tr>
<tr>
<td>Gravida:</td>
<td>Interpreter Required:</td>
</tr>
<tr>
<td>Para:</td>
<td>If Yes State</td>
</tr>
<tr>
<td>LMP:</td>
<td>Language:</td>
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</tr>
<tr>
<td>Gestation:</td>
<td></td>
</tr>
<tr>
<td>BMI:</td>
<td></td>
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<tr>
<td>B/P:</td>
<td></td>
</tr>
<tr>
<td>Relevant Medication:</td>
<td></td>
</tr>
<tr>
<td>Folic Acid commenced – Date</td>
<td></td>
</tr>
<tr>
<td>Known Allergies:</td>
<td></td>
</tr>
</tbody>
</table>

Risk Assessment and Comments

Please note any relevant obstetric, medical history (including maternal mental health issues) and social risks including drug/alcohol misuse and smoking status.

Relevant Medication:

Folic Acid commenced – Date

Known Allergies:

Type of Antenatal Care Requested

- Midwife Led Care
- Shared Care
- Private A/N Care
- Home Birth
- DOMINO

Signed: _____________________________ Date: _________________

Profession: ___________________________

cc Named Community Midwife

Appendix 2: Risk Assessment Tool for use at MLC Antenatal Clinics
Booking Clinic Criteria: Pregnant women with the following conditions usually require Obstetrician Led care and should be referred immediately

<table>
<thead>
<tr>
<th>Medical History:</th>
<th>Obstetric / Gynaecological History:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes/Endocrine Disease</td>
<td>Uterine surgery including Caesarean section,</td>
</tr>
<tr>
<td>Congenital or known acquired Cardiac disease including hypertensive disease</td>
<td>hysterotomy, myomectomy or cone biopsy</td>
</tr>
<tr>
<td>Epilepsy requiring anticonvulsant drugs</td>
<td>Pelvic floor or bladder repair</td>
</tr>
<tr>
<td>Chronic gastrointestinal disease</td>
<td>Fibroids</td>
</tr>
<tr>
<td>Renal disease</td>
<td>Rhesus Isoimmunisation or other significant</td>
</tr>
<tr>
<td>Auto-immune disorders</td>
<td>Antibodies</td>
</tr>
<tr>
<td>Thrombo embolic disease</td>
<td>Antepartum haemorrhage</td>
</tr>
<tr>
<td>Haematological disorders</td>
<td>Pre-eclampsia, eclampsia</td>
</tr>
<tr>
<td>Neurological disorders</td>
<td>HELLP syndrome (hemolytic anaemia, elevated</td>
</tr>
<tr>
<td>Malignant disorders</td>
<td>liver enzymes, and low platelet count)</td>
</tr>
<tr>
<td>Asthma requiring routine medications</td>
<td>Puerperal Psychosis</td>
</tr>
<tr>
<td>Drug or Alcohol Misuse</td>
<td>Grand multiparity (parity four or more)</td>
</tr>
<tr>
<td>Obesity, BMI ≥ 30 at first contact</td>
<td>Previous abortions/miscarriages &gt; 3 times</td>
</tr>
<tr>
<td>Underweight BMI&lt; 18 kg/m² at first contact</td>
<td>Previous stillbirth or neonatal death</td>
</tr>
<tr>
<td>HIV or HBV infection</td>
<td>Premature labour (&lt;37 weeks)</td>
</tr>
<tr>
<td>Teenager aged 16 years or younger</td>
<td>Low birth weight baby &lt; 2.5 kg</td>
</tr>
<tr>
<td>Pre existing or past Mental Illness</td>
<td>Small-for-gestational-age infant (below 5th centile)</td>
</tr>
<tr>
<td></td>
<td>Large birth weight baby &gt; 4.5 kg (above 95th centile)</td>
</tr>
<tr>
<td></td>
<td>Proven or suspected cephalo-pelvic disproportion</td>
</tr>
<tr>
<td></td>
<td>Previous Shoulder Dystocia</td>
</tr>
<tr>
<td></td>
<td>Baby with a congenital abnormality (structural or chromosomal).</td>
</tr>
</tbody>
</table>

Family History
- Domestic Violence
- Unstable/Severe Mental Health Disorder

Social History
- Other children under care of Social Services

Antenatal Period Criteria: Criteria for referring Antenatal Women for Obstetric opinion

<table>
<thead>
<tr>
<th>Any of the above</th>
<th>Polyhydramnios or oligohydramnios</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple pregnancy</td>
<td>Woman's or professional concern about fetal growth or behaviour</td>
</tr>
<tr>
<td>Abnormal ultrasound scan</td>
<td>Fetal death</td>
</tr>
<tr>
<td>Placenta Praevia</td>
<td>Vaginal bleeding (except show &gt; 37 weeks)</td>
</tr>
<tr>
<td>Gestational diabetes or abnormal glucose tolerance test</td>
<td>Breech presentation after 34 weeks gestation</td>
</tr>
<tr>
<td>Hypertension: SBP &gt; 150mmHg-DBP &gt; 90mmHg on 2 occasions 30 mins apart</td>
<td>Unstable lie after 36 weeks</td>
</tr>
<tr>
<td>Epigastric pain</td>
<td>Premature labour, i.e. before 37 weeks</td>
</tr>
<tr>
<td>Development of red cell antibodies</td>
<td>Spontaneous rupture of membranes before 37 weeks</td>
</tr>
<tr>
<td>Anaemia &lt;9g/dl</td>
<td>Primiparous women with a high fetal head at term</td>
</tr>
<tr>
<td>Sepsis: suspected or confirmed</td>
<td>Where I.O.L. is indicated for whatever reason</td>
</tr>
<tr>
<td>Suspected deep venous thrombosis</td>
<td>40 week appointment - for decision regarding I.O.L.</td>
</tr>
<tr>
<td>Unilateral leg oedema</td>
<td>42 weeks gestation - for monitoring.</td>
</tr>
</tbody>
</table>

Note: the criteria set out above is not intended to be exhaustive and should include any woman presenting with any other condition that the midwife, GP or Obstetrician deems to require consultant led care. Following assessment the woman may return to MLC at the discretion of the Obstetrician.

Laminated copy to be available for reference at all MLC A/N Clinics
## Appendix 3: Midwifery Led Care - Antenatal Appointments Schedule (NICE, 2008)

<table>
<thead>
<tr>
<th>Gestation</th>
<th>Care Giver</th>
<th>Focused Activity</th>
<th>Plan:</th>
<th>Please file in MHHR</th>
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</thead>
<tbody>
<tr>
<td>Booking appointment &lt; 10+6 weeks Parallel Clinic Midwife</td>
<td>Midwife Code: MLC Obstetrician Code:</td>
<td>• MHHR initiated • Review GP Referral Letter • NIMATS A/N screening &amp; Risk Assessment Tool • Routine A/N observations &amp; A/N Screening Bloods • Ultrasound scan for viability, EDD, fetal growth chart • Heath Promotion Information: lifestyle choices, folic acid, • Place of Birth options discussed with ‘Lower Risk’ women • Midwife Led Care A/N Appointments Schedule discussed. • Note preference and ‘Lead’ professional in MHHR • Make 40 week Consultant Obstetrician appointment. Additional appointments may be arranged at the request of the woman and at the discretion of the midwife.</td>
<td>Review in</td>
<td>wks Date:........................ Sign:.................... Time:........................ Role:........................</td>
</tr>
<tr>
<td>16 - 18wks Midwife</td>
<td>• Review, discuss and record the results of all A/N screening blood tests • Record blood results on NIMATs, discuss and organize Anti-D if required • Routine A/N observations</td>
<td></td>
<td>Review in</td>
<td>wks Date:........................ Sign:.................... Time:........................ Role:........................</td>
</tr>
<tr>
<td>18 +6 - 20+6 wks. Ultrasoundographer</td>
<td>25wks Midwife</td>
<td>• Ultrasound screening for structural anomalies • Report anomalies to Consultant • Confirm gestational age</td>
<td>Review in</td>
<td>wks Date:........................ Sign:.................... Time:........................ Role:........................</td>
</tr>
<tr>
<td>25wks Midwife</td>
<td>• Review USS report • Routine A/N observations • Discuss date for A/N Education • Give information on Breastfeeding, Vitamin K, Newborn Blood Spot, Hearing Screening and Prevention of Cot Death</td>
<td>Review in</td>
<td>wks Date:........................ Sign:.................... Time:........................ Role:........................</td>
<td></td>
</tr>
<tr>
<td>30wks Midwife</td>
<td>• Routine A/N observations • FBP and Antibody check • Anti-D prophylaxis - rhesus-negative women (NICE, 2008b)</td>
<td>Review in</td>
<td>wks Date:........................ Sign:.................... Time:........................ Role:........................</td>
<td></td>
</tr>
<tr>
<td>32 wks Midwife Prims only</td>
<td>• Routine A/N observations • Review, discuss and record the results from 30 wks • Discuss Birth Plan, active birth and signs of labour</td>
<td>Review in</td>
<td>wks Date:........................ Sign:.................... Time:........................ Role:........................</td>
<td></td>
</tr>
<tr>
<td>34 wks Midwife</td>
<td>• Routine A/N observations • Review, discuss and record the results from 30 wks • Discuss Birth Plan, active birth and signs of labour</td>
<td>Review in</td>
<td>wks Date:........................ Sign:.................... Time:........................ Role:........................</td>
<td></td>
</tr>
<tr>
<td>36 wks Midwife</td>
<td>• Routine A/N observations • Breastfeeding technique and management (UNICEF, 2009)</td>
<td>Review in</td>
<td>wks Date:........................ Sign:.................... Time:........................ Role:........................</td>
<td></td>
</tr>
<tr>
<td>38wks Midwife</td>
<td>• Routine A/N observations • Check consultant appointment</td>
<td>Review in</td>
<td>wks Date:........................ Sign:.................... Time:........................ Role:........................</td>
<td></td>
</tr>
<tr>
<td>40wks Parallel Clinic Midwife &amp; Obstetrician</td>
<td>• Routine A/N observations • Arrange IOL date (T+10 - T+14) and give IOL pack</td>
<td>Review in</td>
<td>wks Date:........................ Sign:.................... Time:........................ Role:........................</td>
<td></td>
</tr>
<tr>
<td>41 wks Midwife</td>
<td>• Routine A/N observations • Offer membrane sweep (NICE, 2008)</td>
<td>Review in</td>
<td>wks Date:........................ Sign:.................... Time:........................ Role:........................</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4: Letter of Referral/Transfer to Consultant Obstetrician Care

<table>
<thead>
<tr>
<th>Midwifery-Led Antenatal Services</th>
<th>Patient Addressograph label</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mid Ulster Hospital</td>
<td></td>
</tr>
<tr>
<td>Magherafelt BT455EX</td>
<td></td>
</tr>
<tr>
<td>Tel. 02879366799</td>
<td></td>
</tr>
<tr>
<td>Fax. 02879366838</td>
<td></td>
</tr>
</tbody>
</table>

| Name:                           |
| Address:                        |
| Postcode:                       |
| D.O.B:                          |
| Hospital No:                    |
| GP:                             |
| HC:                             |

| Date:                           |
| EDD:                            |
| Para:                           |

Dear Dr. .......................... Consultant Obstetrician

Miss/Mrs/Ms............................. had been attending the Midwifery-Led Antenatal clinic at the Mid Ulster Hospital. She is now ........ weeks gestation and the following complications have arisen during the pregnancy, thereby warranting referral/transfer (delete) of her care to Consultant-led care.

This decision has been fully discussed with Miss/Mrs/Ms ............................. and she understands the necessity for the specialist obstetric care provided by your medical team.

If you have any queries or require any further information, please do not hesitate to contact us at the above address.

Yours sincerely

Signed _________________________

Print Name _______________________

On behalf of the Mid-Ulster Midwifery-Led Antenatal Care Team.

Note: send signed copy to Consultant Obstetrician’s secretary
cc MHHR
cc GP
cc MLC office – please retain for monthly audit
Appendix 5: Letter to GP

Mid-Ulster Midwifery-Led Antenatal Services
Mid Ulster Hospital
Magherafelt
BT45 5EX
Tel. 028 7936 6799
Fax. 028 7936 6838

Patient Addressograph label

Name:  
Address:  
Postcode:  
D.O.B:  
Hospital No:  
GP:  
HC: 

Date:  
EDD:  
Para:

Dear Dr.................................................................

-------------------

Miss/Mrs/Ms.............................. has attended the Mid Ulster Hospital to book for her antenatal care. Following discussion of the options of care, she has chosen to attend the Midwifery-Led Antenatal clinic.

In the event of obstetric/medical complications arising she will be referred to a Consultant Obstetrician.

If you have any queries or require any further information, please do not hesitate to contact us at the above address.

Yours Sincerely,
Signed..............................................................

Print Name..................................................

On behalf of the Mid-Ulster Midwifery-Led Antenatal Care Team.

Cc: MHHR
Cc: MLC office – please retain for monthly audit
### Appendix 6a: Obstetric/MLC ‘Booking’ Appointment Slip

<table>
<thead>
<tr>
<th>Addressograph label</th>
</tr>
</thead>
<tbody>
<tr>
<td>Para…</td>
</tr>
<tr>
<td>Monitoring MLC uptake: complete for all women</td>
</tr>
<tr>
<td>Assessed as suitable and</td>
</tr>
<tr>
<td>please tick</td>
</tr>
<tr>
<td>chose MLC Antenatal Services option</td>
</tr>
<tr>
<td>seen today by MLC Midwife</td>
</tr>
<tr>
<td>Consultant Obstetrician</td>
</tr>
<tr>
<td>Staff Grade</td>
</tr>
<tr>
<td>has not chosen MLC Antenatal Services option</td>
</tr>
<tr>
<td>Reason:</td>
</tr>
<tr>
<td>not suitable for MLC A/N Services option</td>
</tr>
<tr>
<td>Reason:</td>
</tr>
<tr>
<td>Action Plan:</td>
</tr>
<tr>
<td>16-18 weeks at MLC Clinic or Consultant (Please delete)</td>
</tr>
<tr>
<td>16-20 week Scan</td>
</tr>
<tr>
<td>40 weeks Consultant Clinic</td>
</tr>
<tr>
<td>Comments:</td>
</tr>
</tbody>
</table>

*Addressograph label*

**Please return this slip to the MLC Midwife for monitoring purposes**

---

### Appendix 6b: Obstetric/MLC 40 Weeks Appointment Slip

<table>
<thead>
<tr>
<th>Addressograph label</th>
</tr>
</thead>
<tbody>
<tr>
<td>Para…</td>
</tr>
<tr>
<td>Monitoring MLC uptake: complete for all women</td>
</tr>
<tr>
<td>At Initial Booking appointment assessed as ‘suitable’ and</td>
</tr>
<tr>
<td>please tick</td>
</tr>
<tr>
<td>chose MLC Antenatal Services</td>
</tr>
<tr>
<td>remained under MLC throughout A/N period</td>
</tr>
<tr>
<td>seen today by MLC Midwife</td>
</tr>
<tr>
<td>Consultant Obstetrician</td>
</tr>
<tr>
<td>Staff Grade</td>
</tr>
<tr>
<td>had not chosen MLC Antenatal Services option</td>
</tr>
<tr>
<td>not suitable for MLC A/N Services option</td>
</tr>
<tr>
<td>Outcomes Evaluation: MLC A/N women only</td>
</tr>
<tr>
<td>Referral at any stage to Consultant Obstetrician Led A/N Care</td>
</tr>
<tr>
<td>Referred by the MLC midwife</td>
</tr>
<tr>
<td>Referred by the GP</td>
</tr>
<tr>
<td>Gestation……………………weeks. Reason…………………………</td>
</tr>
<tr>
<td>Gestation……………………weeks. Reason…………………………</td>
</tr>
<tr>
<td>Returned to MLC A/N Care at ……weeks</td>
</tr>
<tr>
<td>Remained under Consultant Obstetrician Led Care</td>
</tr>
<tr>
<td>Fully Transferred to Consultant Obstetrician Led A/N Care</td>
</tr>
<tr>
<td>Gestation……………………weeks. Reason…………………………</td>
</tr>
<tr>
<td>Comments:………………………………………………………………</td>
</tr>
</tbody>
</table>

**Please return this slip to the MLC Midwife for monitoring purposes**

---

Mid-Ulster Midwifery-Led Care Antenatal Services Operational Guidance
Appendix 7: Recording Mid Ulster Midwifery Led Care (MLC) Service on PAS

All Obstetric Patients referred to Mid Ulster antenatal Clinics will be referred and booked initially for a Consultant Led Service (there will be no direct booking to MUH MLC for 1st appointments)

Patient referred by GP for attendance at Mid Ulster Hospital Antenatal Service
Referral is registered on PAS
to either Dr Stewart or Dr El Tuhamy’s Obstetric clinics

Patient booked for “new” attendance at Consultant Led Obstetric Clinic

Patient Cancels Appt
PAS Function: CAP/CRB

Not further appts requested – registration on PAS is closed

Patient attends for 1st appointment and is seen by Consultant

Patient suitable for MLC service and chooses to change to MLC service

Patient suitable for MLC service and Does NOT want to change to MLC service

Patient will continue as “Follow Up” attendee at the Consultant Led Clinic
Using open OAN Registration

Patient DNA’s 1st appt at Cons Led Clinic

Referred back to GP – registration on PAS is closed

Subject to MLC Suitability Criteria

Patient not suitable for MLC service

Patient suitable for MLC service and Does NOT want to change to MLC service

Patient suitable for MLC service and chooses to change to MLC service

When patient is arranging next hospital appointment, OPD clerk at clinic should be informed that Patient has been accepted for MLC care

ON PAS:
- A new registration should be opened on PAS for “MLC” Clinic template.
- The next (1st at MLC clinic) attendance for the patient should be booked for this MLC clinic, to be booked as “NEW” appointment slot.
- Subsequent attendances at MLC clinic should be booked as “Follow Up” attendances.
- OAN Registration for the Consultant Service should remain OPEN so that patient can be booked in as a REVIEW patient if she needs to be seen at Consultant clinic again during pregnancy (referral back for consultation/opinion).

When patient is admitted to Antrim Area Hospital for Interpartum Care both the MLC OAN Registration and the original Consultant Led OP Clinic registrations should be closed on PAS
Appendix 8: Letter of Information

Midwifery-Led Ante-Natal Clinic
Mid Ulster Hospital
Magherafelt
BT45 5EF
Tel: 028 7936 6799
Fax: 028 7936 6838

Dear……………………………..

We are writing to inform you of an enhancement in the provision of Antenatal Care for pregnant women who reside in the Mid-Ulster area. From 1st October 2010 we will offer Midwifery-Led Care Antenatal Services to any pregnant woman who expresses an interest in this type of care, is assessed to be at lower risk of obstetrical or medical complications, is registered with a GP within Mid Ulster area and is booking for Antrim Hospital Maternity Unit.

A team of midwives will be the lead professionals in the provision of Antenatal Care for women who meet the set criteria. At the first ‘Booking’ appointment pregnant women will be assessed for their suitability for the Midwifery Led Care Antenatal Services option. In the event of obstetric/medical complications arising during the pregnancy, the woman will be referred to a Consultant Obstetrician for further advice and treatment if necessary.

The provision of this option of care is in accordance with our Maternity Services Strategy in which we declared our intention to enhance patient choice. Our aim is to make more choices available locally and to continue to involve women fully in the decision making processes. We have consulted with women and they tell us this is the kind of service they would like.

The main objectives of the Midwifery-Led Care Antenatal Services are to:

- Increase choice in Antenatal Care Services
- Increase women’s control in the decision making process.
- Increase flexibility with regards to place and times of reviews.
- Increase continuity of carer and consistency of care through a team approach.
- Empower mothers and midwives.

We hope to liaise with you in the future as we rely on your support to continue to provide our service to the community.

Yours sincerely,

Signed…………………………………Status……………………………

Print Name……………………………….

On behalf of the Mid-Ulster Midwifery-Led Antenatal Care Team
Appendix 9: What is Midwifery Led Antenatal Care: Patient Information Leaflet

How do I book for Midwifery-Led Care Antenatal Services?

There are a number of ways to get an appointment with the Mid-Ulster MLC Antenatal Services.

You can contact the MLC Antenatal Team directly and make an appointment.
or
Your GP or local midwife can refer you
or
At your first booking appointment at the Mid Ulster Hospital, you will be assessed
and if you meet the criteria you will offered the option of attending MLC Antenatal Services

MLC Antenatal Clinics are held at Mid Ulster Hospital, Magherafelt Outpatients Dept. on:
Mondays or Thursdays: 1.30pm – 4.30pm (New bookings)
Fridays: 1:30pm – 4.30pm (Review appointments only)

The provision of this option of care is in accordance with our Maternity Services Strategy in which we declared our intention to enhance patient choice.

You can contact the MLC Antenatal Team office directly by telephone. If you leave a message a midwife will contact you by the next day.

Midwifery-Led Care Antenatal Services
Mid Ulster Hospital,
Magherafelt,
BT45 0EF
Tel: 028 7936 6799

Email: info@northerntrust.hscni.net
Website: www.northerntrust.hscni.net

This document is available, on request, in accessible formats, including Braille, CD, audio cassette and minority languages.
What are Midwifery-Led Care Antenatal Services?

Midwifery Led Care (MLC) Antenatal Services are provided by a team of experienced midwives who will be the lead professional caring for women with uncomplicated pregnancies.

The MLC Team will provide care throughout the antenatal period and will continue caring for women and their babies at home during the early postnatal period.

Our aim is to make more choices available locally and to involve women in the decision-making processes.

Who can have Midwifery-Led Care Antenatal Services

MLC Antenatal Services will be available for pregnant women who:

- Are assessed to be at lower risk of obstetric or medical complications.
- Express an interest in this type of care.
- Live within the Mid Ulster area.
- Are registered with a GP at a local Health Centre.
- Are booked for Antrim Hospital Maternity Unit.

Why should I choose the Midwifery-Led Care Antenatal Services option?

Choosing the MLC option will increase your choice and control and provide you with continuity of care during your pregnancy.

MLC is designed to help you to get to know your midwives and to establish a relationship of mutual trust and respect.

The service is professional, flexible, and adapted specifically to meet your individual needs. For example, MLC midwives will offer you increased flexibility by arranging antenatal appointments to suit you either at the hospital or at your GP surgery.

In summary:

MLC Antenatal Services should:

- Increase your choice in antenatal care options.
- Increase your control in the decision-making process.
- Increase the flexibility with regards to time and place of reviews.
- Increase the continuity of care and consistency of advice you receive.
- Empower both mothers and midwives.

What if a problem arises during my pregnancy?

At your booking appointment a midwife will ask you screening questions to assess if you are suitable for this type of care. If you are considered to be at lower risk of developing complications then you will be offered MLC antenatal care.

The final decision will be taken by you in consultation with your partner, midwife, obstetrician and/or your GP.

The MLC midwives will continually assess you as the pregnancy progresses. In the event of obstetric/medical complications arising, the midwife will discuss the issues with you and refer you to a Consultant Obstetrician for further advice and treatment if necessary.

You should inform the MLC Antenatal Services Team if you have any concerns.